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Chaplain Care of the Dying Patient

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Introduction

This paper comes as a product of my experiences at Walter Reed Army Medical Center. As a staff chaplain, working intermittently with terminally ill patients over a two year period, and as a patient for several weeks on the cardiac ward, I became convinced that no person within the military structure has a greater challenge, or stands in a position of greater responsibility as does the chaplain in serving the dying. The medical doctor and the funeral director come as close to sharing this position as any other professional, but each has his particular area of concern which scarcely touches in any manner that of the chaplain.

The medical doctor is consumed primarily with his responsibility of preserving life, which in cases of the terminally ill is usually reduced to keeping him as comfortable as possible. The funeral director's major task is that of providing temporary "technical and mechanical" comfort to the bereaved. Yet, these skills, no matter how proficiently learned and manipulated, can never produce the empathy and understanding needed to enter into and share the weight of sorrow and grief experienced by the terminally ill patient himself.[1]

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[1] A terminal patient is defined as one who has an illness that has such a massive effect upon his body that present medical skill and knowledge, in the eyes of the attending physician(s), cannot permanently alleviate it.

For this reason the chaplain's ministry to the dying is both critical and essential. It has been described by Samuel L. Feder in this way: "I don't have any idea how we help a person to die; but I am sure we can do much to help a person live until the time of death."[2] Hopefully the relationship between the chaplain and the patient will be marked by sufficient trust and confidence to affirm and support his worth even in the midst of dying.

It will be my task here to discuss some of the basic considerations which I have gleaned from my brief experiences which I believe must be handled both prior to and during one's ministry to these persons. These include: the chaplain's personal confrontation with his own death, his role as a human being, counselor, theologian and pastor, and his special position as a member of the hospital healing team.

I. The Chaplain and the Fact of Death

The chaplain, as he seeks to minister to the terminally ill, must be honest in facing the fact of death in his own life. His view of death, whether developed or undeveloped, realistic or unrealistic, will become evident in his attempt to communicate with the dying. He can do little about the general views of death within society, but he can examine, improve, and alter his own attitudes, thoughts, and feelings about death; thus, equipping himself better for his ministry. In dealing with the dying, it is not so much a matter of learning the "right" technique, as it is a matter of coming to terms with one's own concept of

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[2]Samuel L. Feder, "Attitudes of Patients with Advanced Malignancy," in Death and Dying: Attitudes of Patient and Doctor (New York: GAP, 1965), p. 622.

and feelings about death, and their expression in and through one's encounters with the dying.

As one who has come close to death on at least four occasions, these experiences have enabled me to understand better the fears and frustrations of the terminally ill, and to empathize in a manner which was completely foreign in my prior ministry.

I have noted, for instance, that it is very difficult for the young chaplain to appreciate the importance of his task with the dying, especially the robust man who has never known such illness from the inside.

Several years ago, just following my ordination, I visited a relative in the terminal stages of cancer. She was a lovely woman in her early forties, leaving her husband and two teenage sons. After fumbling for the "appropriate" words of comfort, I recall the sense of despair in her voice when she said to me, "You know what's wrong with me, so does everyone else around here, but you, like them, just blithely tell me to cheer up and everything will be fine. But it's not. I'm going to die. You don't know what it's like. I hate it." I had obviously failed her, discovering quickly in my young years that there are some things which seminary and ordination cannot confer upon you.

Since that time I have been brought close to death on the battlefield and as the result of a heart attack. Thus, I feel now that I speak not only as one who has sought to minister to those who knew they were going to die, but also as one who has personally come close to traveling that road himself. Perhaps that is why the following quote says so much to me personally:

> ...God walks with you at all times and in all places. He Who is the Great Healer has made you the vehicles of His Healing Power. Perhaps it will not be until you have need of that Power for your own healing, that you will understand and acknowledge that you are His servants, commissioned to do His Will for His souls.[3]

For the chaplain who has not tasted the bitterness of sorrow and grief, it is, therefore, wise for him to consider seriously why he is in the hospital or on the ward. He will probably have answered this question theologically as a response to God's command to minister "unto one of the least of these." But he needs to answer the question emotionally as well, for this is the level at which he operates most of the time, and is basic in understanding his real effectiveness in ministering to the sick. Cabot and Dicks write:

> By what right am I here? By what right do I see you in the intimacies of your pain, your humility?...By what right do I dare hold up an ideal for you in your pain, or express your longings in prayer. Only by right of serving you...Devotion is the minister's badge of office when he goes to a sufferer.[4]

In the midst of this theological inquiry and pastoral devotion, the chaplain must come to grips with his own anxieties and frustrations, irritations and feelings of inadequacy. His level of awareness and insightful acceptance of them, will greatly interfere with or enhance his effectiveness in relating pastorally to the dying.[5]

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[3]The Reverend Father Vincent Fish, "Problems Which Confront the Clergy," (unpublished Position Paper for Symposium on Ministry to the Dying and Bereaved, November 4, 1972, Columbia University, New York City), p. 22.

[4]R. C. Cabot and R. L. Dicks: The Art of Ministering to the Sick, (New York: Macmillan Company, 1936), p. 24.

[5]Robert B. Webb, Jr., "Exploring the Chaplain's Feelings Concerning His Own Death," Bulletin of the American Protestant Hospital Association (March, 1970), pp. 117-125.

Some chaplains resolve their anxieties and frustrations by reciting formalized religious statements, Scripture quotations, and prayers. Although each of these methods are valid, they are used by many chaplains to escape from the specific questions being asked and emotional turmoil being felt by the dying.[6]

Ministry to the dying is particularly difficult because negative feelings concerning the eventuality of one's own death are often aroused when one relates to the dying. In addition, there is the increased ambiguity of the concept of hope in the face of certain death and the cultural attitudes and customs of our society which regard death as a fearsome and unnatural thing to face or talk about.[7]

Speaking directly to this issue, Buel W. Dalton recently presented a paper to the Foundation of Thanatology in New York City in which he wrote:

> ...the performance of this ministry...to the dying is a pastoral duty that is dreaded, if not indeed, shunned by many ministers...This is, indeed, ironic since the minister stands in a unique position and is, hopefully, prepared to span the gulf and speak an authoritative word in both the realm of life and...death...The reasons for the minister's reluctance to engage in this ministry...may be myriad, ranging all the way from a sense of inadequate training to an inability to personally empathize and enter into the sufferings of others or to a personal fear and dread of death itself.[8]

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[6]Avery D. Weisman, "On the Value of Denying Death," Pastoral Psychology (June, 1972), pp. 24-25. He also notes that the clergy "may use theological inventions to push death aside," and observes that "ritualized behavior spares us much anguish..."

[7]N. H. Cassem, "Pastoral Care of the Dying Patient," Pastoral Psychology (June, 1972), pp. 52-61.

[8]Buel W. Dalton, "Problems in Ministering to the Bereaved and the Dying," (unpublished Position Paper for Symposium on Ministry to the Dying and Bereaved, November 4, 1972, Columbia University, New York City), pp. 2-3.

In fact, it is stated by Neale that there is reason to believe that chaplains, with the need to be the custodians of belief in an after-life and/or of the continual care of a loving God, may be more susceptible to doubts, fears, and frustrations, than some other professionals on the healing team.[9]

Thus, one of the most important and necessary preconditions in a chaplain's ministry to the terminally ill is that he have the willingness and strength to look deeply within himself, not only in terms of "checking" his attitudes towards living and dying, but also in addressing himself consciously to what might be called the eternal questions - "From whence came I: And to whither do I go?" Allied with this is the actual coming to terms with answers that are meaningful and significant for himself.

Having briefly looked at the chaplain's personal confrontation with death, and his need to be honest with himself concerning his thoughts and feelings, I would like to suggest four primary aspects of his ministry which he needs to consider if he intends to provide an adequate service to the dying. It is assumed here that the chaplain is prepared with the typical resources of prayer, Scriptures, Sacraments and general knowledge of pastoral counseling. What follows will include some expansion of and suggestions concerning the appropriate use of these resources and their impact upon the patient.

From my experience and study, it seems to me that there are four essential aspects of the chaplain-patient encounter which can be identified, and, therefore, must be understood and dealt with by the chaplain.

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[9]Robert E. Neale, "Explorations in Death Education," Pastoral Psychology (November, 1971), pp. 33-35.

All four need not play a part in every relationship, but they must at least be available if one is to be identified as a chaplain, as opposed to any other member of the healing team. They are: the chaplain as (1) a person, (2) a counselor, (3) a theologian, and (4) a pastor.

II. The Chaplain As a Person

First, beneath all vestments and insignia, the chaplain is a person. He experiences the normal range of human feelings. He is irritable, elated, tense, bored or depressed, depending on the circumstances. When confronted for the first time by a patient who says, "I'm here to die," he, like anyone else with feelings, may become anxious and uncomfortable.

Thus, how he relates himself as a total person to other persons and/or situations evokes from him a style. This style is apparent regardless of the person he encounters (adult, child, friend, patient), or the role he assumes (parent, friend, professional). The effectiveness of his style then becomes dependent upon his relationships with others, although it may be artificially enhanced or inhibited by his insignia (white coat, rank, cross, or clerical collar).

The chaplain must focus primarily on a meaningful encounter with terminal patients. Only then can he begin to accomplish his first function in ministering to the dying—to give him a chance to go on being himself.[10]

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[10]Cecil Saunders, "The Moment of Truth: Care of the Dying Person," in L. Pearson, ed., Death and Dying (Cleveland: Case Western Reserve Press, 1969), pp. 49-54.

I have discovered both through my experiences as a hospital chaplain and as a patient, that quite often what the dying person wants and needs most is a concerned, listening presence. He is very often impersonalized by the institutional setting; and has lost confidence in himself, his fellow beings and his God, if he has one. He is frightened of the unknown which lies ahead. He seeks the care and support of another human being who will probe his feelings and confront him concerning his illness and coming death.

Under such dire circumstances the chaplain's visit will help to restore the patient's sense of worth and dignity. Through a bond of sharing, an affinity of one for the other, there is established a relationship of one human with another; implying trust, sharing, and concern. As one man recently put it: "It is the man of God working as the man of Man."[11]

The chaplain has the task of relating, accepting, and listening. In some instances, this can be extremely difficult. I recall my frustrations upon visiting a man who was unable to speak. I was suddenly made aware of all my words and my personal anxieties that he could not respond verbally to my questions and comments.

He signaled for me to approach the bed, took hold of my hand, and merely by squeezing it at appropriate times, communicated in a way I had never realized could be done. Later, on similar occasions, I took the initiative with other patients in using this method of re-

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[11]J. R. Proulx, Ph.D., "Counsel and Care: Alternatives to Curing in Ministration to the Dying," (unpublished Position Paper for Symposium on Ministry to the Dying and Bereaved, November 4, 1972, Columbia University, New York City), p. 2.

lating, often much to their delight as well as my own. Sometimes relating and communicating can be as subtle and simple as that.

In some cases, the chaplain's person, his physical presence is extremely significant in his ministry. Some of the deepest messages he can give are non-verbal. Healers have long known that a touch is worth many words. Dr. Wertham, describing his experiences both prior to and following an operation writes:

> I remember only two factors which alleviated my general feeling of insecurity before and during my surgery. One was the voice of the operating surgeon, and the other was the reassurance derived from definite physical contact with my pastor.[12]

The chaplain must develop a deep interest in and concern for the quality of his human encounters, most especially with the terminally ill. There is a natural resistence toward tackling the tragic problems of suffering, disease and death; but failure on the part of the chaplain to attempt to establish a relationship of trust and confidence early can prevent the patient from talking about those things that are weighing heavy on his mind during this crisis. If this happens, the chaplain has failed his patient, himself, and his God.

III. The Chaplain as Counselor

Every chaplain, by virtue of his position, is asked for advice. The patient's doubts, fears and questions are often presented to him for his comments and/or suggestions. As the chaplain provides instruction or gives his opinion relative to those matters which concern the patient, he functions as a counselor. It is, therefore, important that

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[12]Dr. F. Wertham, "A Psychosomatic Study of Myself," in M. Piner and B.F. Miller, ed., When Doctors Are Patients (New York: Norton Publishing Company, 1952), p. 84.

he have some ability and skill in understanding just what it is that happens when two people encounter one another.

He must have the expertise to identify the patient's particular problem(s). He must be aware of the emotional and rational states which exist in both the patient and himself. When he has this expertise and awareness he will then be able to provide that adequate, timely, and unbiased counsel which will provide the patient with knowledge and strength to cope with his terminal condition.

The impact of terminal illness often has emotional effects of a profound sort which demand the special attention and care of the chaplain in particular. A sensitive response to these emotional effects requires from him a solid understanding of the stages through which a patient passes in coping with his feelings about his coming death. Elisabeth Kubler-Ross has outlined these stages and discussed them in detail in her splendid book On Death and Dying.[13]

The first stage is denial, which the patient uses as sort of a buffer after receiving the usually unexpected and shocking news of his illness. It allows him to collect himself, and, with time, mobilize other, less radical, defenses. The second stage is anger. Feelings of denial give way to rage, envy, and resentment. "No, not me," is followed by "Why me?" The third stage is one of bargaining for an extension of time, often for a specific purpose, or possibly for a few days without pain. Most of the bargains are made with God and are kept secret.

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[13]Elisabeth Kubler-Ross, On Death and Dying (New York: The Macmillan Company, 1972), pp. 38-137.

However, many are made with doctors, nurses, and the chaplain—who is often seen as God's representative.

Depression is the fourth stage and comes as a result that the patient can no longer deny his illness, and must face the impending loss of all his love objects; his life, family, possessions, work and friends. The fifth stage is acceptance, which comes after the patient has gone through the first four. It is a time almost void of feelings. "It is as if the pain had gone, the struggle is over, and there comes a time for 'the final rest before the long journey'..."[14]

Throughout these stages the chaplain will find the patient experiencing pain, loss of self-esteem, loneliness, and guilt. The obvious impact of severe pain common to cancer and heart disease, for instance, creates variations in the patient's emotional and thought behavior caused by the use of drugs to control and alleviate such pain. The chaplain should not be surprised at this. He should understand that these variations are not to be taken lightly, diverted by small talk, or dismissed as meaningless by his own frustrations. It will be his task to recognize such changes of mood as common, remember their cause, accept them, and, when possible, use them in his ministry; perhaps even use them to help the patient explore the meaning of his existence.

The patient who is well aware of the shortness of his life ex-

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[14] Ibid. p. 113. It should be noted that Kubler-Ross would not want one to take the order of these stages so rigidly. For instance, one may skip stage one (denial) and begin at stage three (bargaining). Or after one has gone through depression (or even moved pretty far into the stage of acceptance) he may move back to bargaining or denial. The stages are not static, but dynamic, continually changing in the dying patient.

periences loss of self-esteem.[15] The robust and self-made man suddenly reduced to ineffectiveness by a terminal heart disease (as is quite often true in the military), or the woman who has prided herself on her beauty, striken by an incurable malignancy, demand support as a broken limb needs a splint. Dr. Kubler-Ross, in her chapter on "Depression," notes that loss of self-esteem can be extremely devastating to the patient.[16] It will be helpful and supporting if the chaplain can take time to encourage him to talk about his loss and resentment.

There is a loneliness in illness that commands the presence and expertise of the counselor-chaplain. Often he is the only one who can really minister. If religious faith has anything to it, it is this, that it has a perspective toward humanity that transcends man's mortality and provides the chaplain with the opportunity to discuss with any man that which occurs to every man. At a time when physicians and nurses are busy and family and friends are grieving, he can provide a presence and ministry unattainable by any other person.

This is quite true in the area of guilt. Guilt for past wrongs, and present suffering and coming death as a punishment for them, is a common element in a patient's reaction to his illness. Dr. Elia, reporting on the research of Ruth Abrams with sixty-five cancer patients, quotes her to the effect that "the patient's concern was shown in the emotions; fear in almost every case; guilt in two-thirds of the patients.[17]

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[15] C. J. Scherzer, "Ego Injury in Illness," Pastoral Psychology (April, 1957), pp. 31-35.

[16] Ibid. Kubler-Ross, On Death and Dying, pp. 85-111.

[17] A. D. Elia, "Spiritual Needs in the Care of the Patient," Pastoral Psychology (April, 1957), p. 24.

Scherzer tells the story of one woman whose guilt for past wrongs surfaced as extreme fear when she faced squarely the fact that death was near. She was unmarried, in her seventies and was found to have advanced cancer of the uterus. She spoke to him of her fear of death. He replied, "You need not be afraid; God is good. He will take care of you..." Several visits and conversations later, she repeated the same fear. Finally, he asked her why she felt so afraid. She replied:

> I was raised a Catholic and my parents were strict. I was confirmed in the Church and everything was all right until I was a senior in high school. I fell in love with a boy and I thought he loved me, too. It hurts me even to think about it. But I really loved him and one night in my home, my parents were asleep upstairs, I lost control of myself and had intercourse with him. I am so ashamed now, but I was sinful, very sinful, Reverend. And it has haunted me ever since.

After this confession and a discussion of God's forgiveness, she told the chaplain on his next visit, "I am no longer afraid to die."[18]

For over fifty years this woman had carried a burden of guilt as a result of this episode. However we may interpret it or feel about it, it was a source of guilt and fear. In this instance, the chaplain was able to relate as a person, counselor and pastor to someone who desperately needed the healing only he had to offer.

It should be mentioned here that throughout his ministry to the terminally ill, the chaplain, regardless of any of the four relationships in which he may be working, must consider two very important factors: (1) the amount of time which he may have to give to any one patient in order to be effective; and (2) the maintainence at all times for the

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[18] C. J. Scherzer, Ministering to the Physically Sick (Englewood Cliffs, N. J.: Prentice-Hall, 1963), pp. 46-47.

respect and integrity of the dying person.

When the deeper emotions and experiences of life are opened up to one who ministers to the dying, they cannot be explored or given adequate expression without many hours of painstaking attentiveness. The great danger lies in the fact that the chaplain often has many opportunities to create an atmosphere in which these emotions and experiences can be initiated, only to discover that he doesn't have time available to follow through. To have to abruptly terminate a relationship can do serious damage, for the patient is left suspended in an unsolved emotional quandry. The only solution to this problem, as I see it, is to let the chaplain always remember that the terminally ill patient and his needs must head his list of priorities.

Another problem faced by the chaplain in his ministry is that of maintaining a reverence and respect for the integrity of the personality of the dying patient by not depriving him the opportunity of working out his own salvation, doing his own grief work, expressing his anger, etc. On this matter, Reverend Dalton writes:

> The unfortunate truth is that clergymen, like parents, teachers and physicians in a sub-conscious effort to give validity to the image of the role thrust upon them by society and circumstances may unwittingly and over-zealously violate the very integrity of the individual they are seeking to serve...This is often accomplished by such innocent gestures as making decisions for them or strongly influencing their decisions and plans according to their own standards. This is often the case when unsolicited advice is given. More serious, however, is the giving of false encouragement...Such malpractice upon human souls is infinitely more devastating and reprehensible than malpractice upon human bodies.[19]

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[19] Ibid. Buell W. Dalton, "Problems in Ministering to the Bereaved and the Dying," pp. 7-8.

The chaplain must seek to provide an atmosphere in which the patient is free to express his rage, fears and fantasies, without thrusting upon the patient his own "hangups."

IV. The Chaplain as Theologian

The third role finds the chaplain functioning primarily as a theologian. He is the one whose training has included a study of God, His attributes and His relations to the universe; more specifically, how He relates to men. The theological meaning of suffering, injustice, despair and death--all must be examined, assimilated and integrated with his personal and theological beliefs concerning God, grace, mercy, the Cross, and Resurrection.

The chaplain, by virtue of his vocation, is a theologian; but he must not be one who lives in an ivory tower. He must explore the tensions between his personal theological beliefs and the realities of life. What does the Resurrection mean in terms of ministering to the dying patient? What is the relationship (if any) between the pain-filled, suffering patient in the bed and the pain-filled, suffering Christ on the Cross? Only when the chaplain honestly copes with such questions as these can he hope to minister to another human being for whom these tensions may be an extreme crisis.

A patient in pain or anguish, whether child, youth or adult, presents a challenge to one's comfort, including the comfort of one's personal faith and theological beliefs. An encounter with a dying patient should be a process whereby the chaplain is challenged to examine his theological foundation and religious growth. This demands

honesty, openness, acceptance and tolerance—not only of the other person, but of the chaplain himself as well.

The Reverend Douglas Cater, chaplain to terminally ill youth in the Illinois Children's Hospital-School, writes:

> These children, probably more than most children, seem to feel a need to have a theory of God's purpose...an assurance that there is some meaning inherent in their misfortune...most of them seem greatly interested in discussing theological issues...and show a desire to believe that God has some good purpose in all that happens.[20]

The chaplain must respond positively and aggressively to the questions posed to him by the misfortunes of life. If he doesn't, he is either dishonest or defensive. And, if his theology is not continually re-examined and re-shaped by his experiences, then his personal faith will become isolated, immature and irrelevant.

Anger and disillusionment with one's own theological formulations is perhaps one of the most noticable negative affects upon one's ministry to the dying. Theological "truths," even when substantiated by the "right" verses of Scripture, often ring hollow in response to a patient's inquiry into the unfathomable and unknowable. Intellectualizations most often offer only cold comfort to patients who are victims of some of the cruelest "jokes" that life can play on an individual.

The chaplain must remember always that he is a very limited human being, as is everyone else; subject to the same forces which all men, in time, must face. Though he may take some comfort in the fact that his

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[20]Douglas G. Cater, "Some Observations Concerning Religious Ministry to Institutionalized Physical Handicapped Children," Journal of Pastoral Care (February, 1963), pp. 85-92.

professionalism may put him in good stead for discussion and speculation on an academic level, in actual experience, he will soon realize that he too stands on the same ground with all others of his species—the inescapable fact of life—death. When all his theological formulae are feeble, his syllogisms insufficient, and his choicest Biblical quotations boring, he too stands on the edge of the abyss of faith like those whom he seeks to serve.

V. The Chaplain as a Pastor

The final aspect of the chaplain's encounters involves his role as a pastor. Just as a stethescope symbolizes and evokes expectation of medical expertise, the lapel cross symbolizes and evokes expectation of religious expertise. Like it or not, the chaplain faces the unequivocal claim of his role, that he is marked as one who is an "expert" pertaining to "things not of this world." This includes most specifically, as mentioned above, God and the way He relates to men and they in turn relate to Him; through faith, prayer, worship, obedience, suffering and death.

The chaplain must ever remember that while he is a person, a counselor and a theologian, he has been called to be foremost a pastor. He must be able not only to relate as a person, use the right techniques, and give out with profound insights on "the nature of man," but he must be equally familiar with "the destiny of man." He must not only be sure of what he believes, but he must know how, as a pastor—a spiritual counselor, to apply these beliefs to the demands of the hour. If he wishes to excell as a comforter to the dying, he must know God and love people very much.

I believe that this is where the chaplain's personal faith and familiarity with Holy Scripture becomes crucial in his ministry. In the case of the chaplain who has not personally been through his own sorrow, these are his only sources of strength and wisdom. The depth of his own faith, even when both he and the patient know he doesn't have all the answers, can still be a source of comfort and hope.

The Bible becomes far more than a book concerned merely with the nature of man (from whence he came), but one which deals far more specifically with the destiny of man (what God has prepared for him). the former provides ample opportunity for the chaplain to play mental games with those who like to take "head trips," but it has little place or value in the hour of sorrow for bringing comfort to the dying.

It should be noted that one of the dangers a chaplain often encounters in his ministry as a pastor to the terminally ill centers around the fact that he is often too ready to use the "tools" of his trade. Chief among these are: his ability to speak, preach and pontificate--all of which he usually does very well. However, it has been my experience, that in the ministry to the dying, the chaplain serves better, on the whole, when he makes the sacrifice of remaining silent.

This should not be interpreted as "doing nothing," but rather it implies that he can often perform his ministry better when he listens receptively while the patient is given free reign to pour out his fears and guilts, anger and frustrations. The chaplain usually can do so much good and so little harm when he is willing to only listen. The

danger comes when he presumes that he, being outside the arena of the patient's sorrow, is in a better position to think clearly, to be more objective, to pass judgment, and to give advice.

As a pastor, the chaplain can help the patient understand that health is not the ultimate end of life. It is ironic that the success of modern medicine, in most areas, is the very source that creates and complicates many of the emotional problems of the dying patient; especially the patient who cannot be helped. His expectations are heightened ("Maybe the cancer cure will be found before I die"), and his bitterness even more easily compounded when his expectations crash ("There's no chance. It's too late). We live in a culture where health and longevity have been made such central values that those denied either or both are left in an emotional chaos and a spiritual vacuum.

It is at this point, perhaps, more than any other, that the chaplain can become relevant in his role as a pastor. It falls upon him to help the patient grope for values that transcend both health and survival, to center his existence in a faith that encompasses even his pain and coming death. In Tillich's words: "...to be grasped by a power that is great than we are."[21]

It is important then to remember that the chaplain has "pointer value." That is, by the very nature of his work, he points beyond himself to ultimate truth and love—and guilt and punishment. The chaplain's

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[21]Paul Tillich, "On Healing," Pastoral Psychology (June, 1955), p. 28.

mission is fraught at all times with theological and pastoral overtones; and the dying often view him as the mediator between themselves and God. He may represent comfort, strength and hope, or failure, weakness and estrangement. But in either case, he is a symbol of many and various frustrations and anxieties.

CONCLUSION

The chaplain, at all cost, must come to terms with the meaning of death in his own life, not theoretically, but practically, ("I am going to die"). When he takes this step, he places himself in a position of being able to reach out as one who travels the same road as those he serves. As he ministers there are four distinct, but not separate roles he plays: as a person, a counselor, a theologian, and a pastor. In order to be an effective chaplain, he must be available as a fellow human being, with some psychological skills, ability to articulate theological maxims, and desire to share himself specifically as a "shepherd of the flock."

The chaplain faces a mutual task with the physician. That their task is even more so interrelated than is common held is hinted in these words from a report on Christian Faith and Health adopted by the United Presbyterian Church in the U.S.A.:

> No longer can the functioning of the human being...be compartmentalized. It is impossible to think any longer in terms of a body which operates according to natural laws and a spirit which operates freely in relation to that which is above nature, that is, God. There is a unity in human personality, and the human being requires a meaningful orientation to life, without which he becomes sick. The religious dimension of health is found in this human need for an integrating principle. Although we cannot yet

> see all the connecting links, it may eventually be shown that no part of the biological or nervous system is totally unaffected by a man's spiritual outlook and moral behavior. Faithfully to communicate God's gift of a meaningful life in Christ is the Church's continuing contribution to the total health of man.[22]

Thus, in any hospital one finds the proud--the humble; the jealous--the gentle; the hateful--the loving; the selfish--the compassionate. Into this paradoxical chaos of confusion and fear the chaplain walks, with his own set of fears, problems, values, and faith; to bring healing to the dying. At unusual times and in strange places they will turn to him; and he in turn will seek to minister to the extent that he is aware of his own emotions, and manifests the fruits of a long-practiced self-discipline and religious faith. These are some of the problems with which the chaplain must struggle as he begins an effective ministry to the dying.

> Lovingly to aid the release of a soul from its tabernacle is is at once the highest privilege and the greatest responsibility afforded a human being...God gives those who minister to the dying, to those who ease the separation of the soul from earthly habitation, the most sacred and intimate role in the spiritual realm of the human being. In this crucible--this sharing of the moment of death which is our common lot--is the answer to the needs of the living, the dying, and the bereaved. We of the Clergy who are privileged to stand with a soul at the spiritual horizon between Heaven and Earth, have our feet upon sacred ground. We must needs remove our earthbound shoes soiled with the thoughts, and words, and deeds which are unworthy of our own souls, shedding also our fears and doubts and confusion, for in these moments of release, we are the servants and handmaids of our God. For a few timeless moments, whatever our personal beliefs and prejudices concerning the existence of a Supreme Being, we are aware of the limitations of our minds, and of a Power beyond the horizon that is impossible for finite minds to comprehend.[23]

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[22]"Christian Faith and Health," Pastoral Psychology (May, 1961), p. 44.

[23]Ibid. Dr. Vincent Fish, "Problems Which Confront the Clergy," pp. 10-11.

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